CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155330	B. WING		02/12/2013
NAME OF	DROWDED OF CURRING			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	X.	200 C	ONNIE AVE	
SALEM	CROSSING		SALEN	/I, IN 47167	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
K0000	REGULATORY OF	ELSC IDENTIFYING INFORMATION)	TAG	BLICEACT	DATE
ROOOO					
	A Life Safety Co	ode Recertification and	K0000	Please find the enclosed plan	of
	-	Survey was conducted by	12000	correction for survey ending	
		e Department of Health in		2-12-13. Submission of this pl	
		42 CFR 483.70(a).		of correction does not constitut	
	decordance with	142 CTR 403.70(a).		admission or agreement by the provider of the truth of facts	
	Survey Date: 02	2/12/13		alleged or correction set forth	on
	Survey Date. 02	2/12/13		the statement of deficiencies.	
	Facility Number	000223		This plan of correction is	
	Facility Number: 000223 Provider Number: 155330 AIM Number: 100267680			prepared and submitted becau	
				of requirement under state and federal law. Please accept this	
	AIM Number:	100267680		plan of correction as our credit	I
		D		allegation of compliance. Due	
	· ·	Brashear, Life Safety		the low scope and severity of t	he
	Code Specialist			survey finding, please find sufficient documentation	
	A. d. T.C.C.C.			providing evidence of compliar	nce
		ety Code survey, Salem		with the plan of correction. The	
	1	und not in compliance		documentation serves to confi	rm
	•	nts for Participation in		the facility's allegation of	
		eaid, 42 CFR Subpart		compliance. Thus, the facility respectfully requests the grant	ina
	` //	Safety from Fire and the		of paper compliance, feel free	
		the National Fire		contact me with any questions	
		ciation (NFPA) 101, Life			
	- ·	SC), Chapter 19, Existing			
		cupancies and 410 IAC			
	16.2.				
	1	acility was determined to			
		00) construction and was			
		d. The facility has a fire			
	alarm system wi	th hard wired smoke			
	detectors in the	corridors and spaces open			
	to the corridors.	plus battery operated			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

smoke detectors in all resident sleeping

(X6) DATE

TITLE

000223

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 03/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 01	(X3) DATE : COMPL			
		155330	A. BUI B. WIN	LDING IG		02/12/		
NA 55 05 5	AD OUTDOOR OF STATES		P. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>		
	PROVIDER OR SUPPLIER		200 CONNIE AVE					
SALEM C	CROSSING			SALEM,	, IN 47167			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
1710		lity has a capacity of 92	+	1110			BATE	
		of 91 at the time of this						
	survey.							
		residents have customary						
	-	nklered and all areas						
	providing facility	y services were						
	sprinklered.							
	Ouality Review	by Robert Booher, Life						
Safety Code Specialist-Medical Surveyor		-						
	on 02/19/13.							
	-	found not in compliance						
		entioned regulatory						
	following:	evidenced by the						
	ionowing.							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet

Page 2 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S							
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		01	COMPLETED	
		155330	B. WING			02/12/2013	
			b. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				NNIE AVE		
CALEMA	CROSSING				, IN 47167		
SALLIVIC	ROSSING			SALEIVI,	, 111 47 107		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018	NFPA 101						
SS=E	LIFE SAFETY CO						
		corridor openings in other					
	•	closures of vertical					
		r hazardous areas are					
		, such as those constructed					
		oonded core wood, or					
		ng fire for at least 20 n sprinklered buildings are					
		esist the passage of					
		no impediment to the					
		ors. Doors are provided					
	•	able for keeping the door					
	closed. Dutch do	ors meeting 19.3.6.3.6 are					
	permitted. 19.3	3.6.3					
		prohibited by CMS					
		health care facilities.					00/04/0040
		ation and interview, the	K001	18	1. The doors in the therapy gy	m	03/01/2013
	facility failed to	ensure 2 of over 100			and activity room had positive		
	doors to the corr	idor were equipped with			latches installed. 2. Facility inspected to ensure no further		
	positive latches a	and latched into the door			areas of concern. 3. Maintenar		
	frame. This defi	cient practice could			Director in-serviced on K018,	100	
		esidents at a time, as well			K021, K029, K046, K069		
	•	ors while in the Physical			regulation (See Attachment A)	by	
		_			Executive Director on 2-26-13.		
	Therapy room or	Activity 100m.			Weekly Preventative		
					Maintenance updated to include	le	
	Findings include	:			inspection of doors (See		
					Attachment B). 4. The Executive Director or designee will comp		
	Based on observa	ations on 02/12/13			a Maintenance Audit (See	icic	
		.m. and 1:45 p.m. during			Attachment C) weekly times 4		
	-	lity with the Maintenance			weeks, then monthly times 3		
		•			months, then quarterly for at le	ast	
	-	Administrator, the doors			6 months. The audits will be		
		r into the Physical			reviewed during the facility's C	QI	
		nd into the Activity room			meetings and issues will be		
	were not provide	ed with positive latches.			addressed and the above plan	will	
	Both doors were	equipped with deadbolts			be altered accordingly if the		
					threshold is not 95% or above.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet Page 3 of 12

PRINTED: 03/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENT	TIFICATION NUMBER:	A. BUILDING B. WING	01	COMPLETED 02/12/2013		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	IENT OF DEFICIENCIES JET BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	only. This was acknown Maintenance Supervision.	sor and the					
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet Page 4 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETE.			ETED	
		155330	B. WIN			02/12/	2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			NNIE AVE		
SVIEWO	CROSSING				I, IN 47167		
OALLINI C	JACOSSING			SALLIVI			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0021	NFPA 101						
SS=E	LIFE SAFETY CO						
		kit passageway, stairway					
		ntal exit, smoke barrier or enclosure is held open only					
		ged to automatically close					
		zone or throughout the					
	facility upon activ	<u>~</u>					
	, , , , , , , , , , , , , , , , , , , ,						
	a) the required m	anual fire alarm system;					
	b) local smoke de	etectors designed to detect					
	smoke passing through the opening or a required smoke detection system; and						
	c) the automatic s	sprinkler system, if					
	installed. 19.2.2						
	Based on observ	ation and interview, the	K00)21	1. All affected areas had		03/01/2013
	facility failed to	ensure 1 of 1 sets of			coordinators installed to allow	the	
	_	the corridor, hazardous			astragal side of the door to clo	se	
	area doors, were				first. 2. Facility inspected to		
	-	ose or close upon			ensure no further areas of		
	-	•			concern. 3. Maintenance Direct was in-serviced on K018, K02		
		fire alarm system. This			K029, K046, K069 regulation	٠,	
	*	e could affect up to 61			(See Attachment A) by Execut	ive	
		ne 100, 200, and 300			Director on 2-26-13. Preventa		
	· ·	staff and visitors while in			Maintenance updated to include	de	
	the main dining	room.			inspection of doors (See		
					Attachment B). 4. The Executi Director or designee will comp		
	Findings include	: :			a Maintenance Audit (See	icic	
	D 1 1				Attachment C) weekly times 4		
		ation on 02/12/13 at			weeks, then monthly times 3 months, then quarterly for at le	ast	
	-	g a tour of the facility			6 months. The audits will be	Just	
	with the Mainter	nance Supervisor and the			reviewed during the facility's C	QI	
	Administrator, tl	ne set of double doors			meetings and issues will be	-	
	between the kitc	hen and dining room			addressed and the above plan	will	
		ne direction and were			be altered accordingly if the		
		n astragal on one of the			threshold is not 95% or above		
	equipped with al	i asu agai on one or the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet

Page 5 of 12

PRINTED: 03/04/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE	DRRECTION IDENTIFICATION NUMBER: 155330	A BUILDING	COMPLETED 02/12/2013
SALEM CROSSING SALEM, IN 47167		OR SUPPLIER 200 CONNIE AVE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPL	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION DATE
doors. When first observed, these double doors were held open by the door with an astragal creating a one inch gap between the doors. This was acknowledged by the Maintenance Supervisor and the Administrator at the time of observation. 3.1-19(b)	ors. When first observed, these double ors were held open by the door with an tragal creating a one inch gap between e doors. This was acknowledged by the aintenance Supervisor and the dministrator at the time of observation.	When first observed, these double were held open by the door with an all creating a one inch gap between ors. This was acknowledged by the enance Supervisor and the histrator at the time of observation.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet Page 6 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	ple construction G 01	(X3) DATE SURVEY COMPLETED 02/12/2013		
		155330	B. WING		– 02/12	/2013
	PROVIDER OR SUPPLIER CROSSING		20	REET ADDRESS, CITY, STATE, ZIP CO O CONNIE AVE ALEM, IN 47167	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	(X5) COMPLETION DATE
K0029 SS=E	hour fire-rated do automatic fire ext accordance with a protects hazardou approved automatic separated from or resisting partitions self-closing and in protective plates inches from the bignormal permitted. 19.3 Based on observing facility failed to kitchen, hazardou equipped with polatched into their deficient practice residents from the halls, as well as the main dining in Findings included. Based on observing between 12:15 puring a tour of the Maintenance Supadministrator, the between the kitch the single door ook itchen and the coprovided with portions.	ed construction (with % ors) or an approved inguishing system in 8.4.1 and/or 19.3.5.4 as areas. When the stic fire extinguishing used, the areas are ther spaces by smoke and doors. Doors are con-rated or field-applied that do not exceed 48 ottom of the door are extensive and interview, the ensure 3 of 5 doors to the us area doors, were ositive latches and or door frames. This is a could affect up to 61 are 100, 200, and 300 staff, and visitors while in room.	K0029	1. All affected doors hat positive latches installed latched into their door for the serviced on Ko18, Ko46, Ko69 regulation Attachment A) by Exect Director on 2-26-13. Positive Maintenance updated to the serviced on Goors (Second Attachment B). 4. The latch Director or designee with a Maintenance Audit (Second Attachment C) weekly the weeks, then monthly the months, then quarterly 6 months. The audits were reviewed during the fact meetings and issues we addressed and the about the second months and second months. The audits were second months and issues we addressed and the about the second months and second months. The second meetings and issues we addressed and the about the second months and the second months and the second months and the second meetings and issues we addressed and the about the second months are second months.	ed and frames. ensure no n. or was 021, K029, (See cutive reventative ro include re Executive fill complete See times 4 mes 3 for at least will be cility's CQI ill be ove plan will if the	03/01/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet

Page 7 of 12

PRINTED: 03/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	01	(X3) DATE COMPL	ETED	
		155330	B. WIN	G		02/12/	2013
NAME OF P	ROVIDER OR SUPPLIER	\			ADDRESS, CITY, STATE, ZIP CODE		
SALEM C	CROSSING				NNIE AVE , IN 47167		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS, DEEDEDANGED TO THE ADDROLOPING	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
		e dining room was open to					
	the egress corrid						
		y the Maintenance					
	Supervisor at the	e time of each					
	observation.						
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet Page 8 of 12

PRINTED: 03/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155330	A. BUII	LDING	01 	COMPLETED 02/12/2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
SALEM C	CROSSING			200 CONNIE AVE SALEM, IN 47167			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
K0046	NFPA 101						
SS=C	LIFE SAFETY CO						
		ng of at least 1½ hour					
	<u>-</u>	ed in accordance with 7.9.					
	19.2.9.1.	raviany and interview the	K00	116	1 Dattery approted lights were		03/01/2013
		review and interview, the	KUC	140	Battery-operated lights were tested for 90 minutes. 2. Faci		03/01/2013
		provide documentation to			inspected to ensure no further	•	
		tery powered light sets			areas of concern. 3. Maintena		
		lly for 90 minutes. LSC			Director was in-serviced on K0)18,	
	101, Section 7.9.	3 requires a functional			K021, K029, K046, K069		
	test shall be cond	lucted annually on every			regulation (See Attachment A)	-	
	required emerger	ncy lighting system for			Executive Director on 2-26-13.		
	not less than 1 1/	2 hours. Equipment			Preventative Maintenance poli states that annual testing will be	•	
		erational for the duration			completed. Maintenance has		
		en records of visual			written "90 minutes" on the Te	st	
		ests shall be kept by the			Log so further inspection can		
	-	tion by the authority			verify how long the test was		
	-	on. This deficient			conducted (See Attachment D 4. The Executive Director or).	
		fect all residents, as well			designee will complete a		
	•	· ·			Maintenance Audit (See		
	as staff and visito	ors.			Attachment C) weekly times 4		
					weeks, then monthly times 3		
	Findings include	•			months, then quarterly for at le	east	
					6 months. The audits will be	.01	
	Based on review	of the battery light			reviewed during the facility's C meetings and issues will be	,QI	
	testing log in the	Life Safety Code book			addressed and the above plan	will	
	on 02/12/13 at 11	1:35 a.m. with the			be altered accordingly if the		
	Maintenance Sup	pervisor and			threshold is not 95% or above.		
	_	esent, there was no					
	_	tation to show the battery					
		ncy light set at the					
	1	sted annually for a					
	duration of ninet	•					
		-					
	•	pervisor confirmed the					
	_	ninety minute annual test					
	tor the battery ba	ck up light set at the time					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet Page 9 of 12

PRINTED: 03/04/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155330	A. BUILDING B. WING	01	COMPLETED 02/12/2013			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	of record review	•						
	3-1.19(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet Page 10 of 12

PRINTED: 03/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	02/12/2013	
		155330	B. WIN	G		02/12/	2013
	PROVIDER OR SUPPLIER			200 CC	ADDRESS, CITY, STATE, ZIP CODE DNNIE AVE 11, IN 47167		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
K0069 SS=B	NFPA 101 LIFE SAFETY CO Cooking facilities accordance with 9 Based on record the facility failed exhaust systems semiannually. N Standard for Ven Protection of Cor Operations, 8-3.1 removal devices, appurtenances sh metal at frequent surfaces becomin with grease or oi exhaust system is shall not be coate substance. The exhaust system is shall be inspected qualified, and cerperson(s) in accordable 8-3.1 requirement with greater volumes shall be inspected deficient practice kitchen staff. Findings include Based on review Inspection report a.m. with the Matthe Administrator	DDE STANDARD are protected in 9.2.3. 19.3.2.6, NFPA 96 review and interview, I to ensure 1 of 1 kitchen was cleaned at least FPA 96, 1998 Edition, atilation Control and Fire mmercial Cooking I requires hoods, grease and to bare all be cleaned to bare and heavily contaminated by sludge. After the so cleaned to bare metal, it ed with powder or other entire exhaust system d by a properly trained, artified company or ordance with Table 8-3.1. ares systems serving e cooking operations d semiannually. This e could affect mostly	K00		1. New contract signed with company to complete cleaning least semi-annually. 2. Facility inspected to ensure no further areas of concern. 3. Maintena Director was in-serviced on Ki K021, K029, K046, K069 regulation (See Attachment A Executive Director on 2-26-13 Preventative Maintenance updated to include semi-annu cleaning of kitchen exhaust systems by contracted provide (See Attachment E). 4. The Executive Director or designer will complete a Maintenance Audit (See Attachment C) westimes 4 weeks, then monthly times 3 months, then quarterly at least 6 months. The audits be reviewed during the facility CQI meetings and issues will addressed and the above plar be altered accordingly if the threshold is not 95% or above	g at / nce 018,) by . al er e ekly / for will /'s be	03/01/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet

Page 11 of 12

PRINTED: 03/04/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155330	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPI 02/12	LETED		
SALEM (ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
IAU	only being cleaned once a year. The most recent date the range hood was cleaned was 11/28/12. This was confirmed by the Maintenance Supervisor at the time of record review. 3.1-19(b)	IAG			DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VZ8Q21

Facility ID: 000223

If continuation sheet

Page 12 of 12